Request for Family or Medical Leave

Name:_____ SSN:_____

Department:_____

Start Date of Anticipated Leave:_____

Expected Date of Return to Work:_____

Type of Leave Requested: ☐ Sick ☐ Vacation ☐ LWOP

Leave Will Be: ☐ Continuous ☐ Intermittent ☐ Reduced Hours

Leave is to Care For: ☐ Self ☐ Spouse ☐ Child ☐ Parent

Reason for Leave:_____

_____

_____

_____

Note: A leave request based on a serious health condition must be accompanied by "A Certification of Health Care Provider."

I hereby authorize Metro Government to contact my physician for clarification related to my leave request.

I understand that failure to comply with reasonable requests from my department regarding this leave may result in denial of leave under the FMLA.

Signature:_____ Date:_____

Note: Maintain original in confidential medical file and send copy to Benefit Services, Department of Human Resources, 222 Third Avenue North, Nashville, TN 37201.